F 000 INITIAL COMMENTS During the annual recertification survey conducted and complaint investigation #28183 August 1 - 3, 2011, at Center on Aging, Erwin, TN., no deficiencies were cited in relation to complaint #28183, under 42 CFR Part 482.13, F 221 483.13(a) RIGHT TO BE FREE FROM Physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This RECUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to assess for the use of a restraint or one resident (#3) and failed to assess for restraint reduction for one resident (#3) and failed (#4) of thirty-two residents reviewed. The findings included: Resident # 3 was admitted to the facility on May 20, 2010, and readmitted on July 6, 2011, with diagnoses of Congestive Heart Failure, Pulmonary Embolism, Hypertansion and intestinal Clostridium Difficile. Medical record review of the Minimum Data Sot (MDS), dated June 17, 2011, revealed the resident making skills: required extensive assistance for transfers and mobility and diff or	AND PLAN	OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE	M APPROY 0. 0936-0 SURVEY LETED
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PRATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	/ a	ssistance for transfer	skills; required extensive	įL			

nor low ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction are disclosable 14 agram participation.

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Event ID: 8U5M11

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If continuation sheet Page 1 of 14

2011-08-09 14:40 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 4237351160 P 5/24 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X8) DATE SURVEY COMPLETED A BUILDING 445424 B. WING NAME OF PROVIDER OR SUPPLIER 08/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE CENTER ON AGING AND HEALTH 880 SOUTH MOHAWK DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ERWIN, TN 37650 PROVIDER'S PLAN OF CORRECTION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE DEFICIENCY) F 221 Continued From page 1 F 221 Restraint assessments done for require the use of restraints. resident # 3 on 8/1/2011, restraint Medical record review of the interdisciplinary progress notes, dated June 12, 2011, revealed reduction assessment done on the resident "...bumped right lower extremity on side rail causing a skin tear ...". Continued review resident # 4 By QA Nurse or of facility documentation, dated June 12, 2011. Designee (Charge Nurse). revealed measures taken to include "..add short pads to rails...". Review of the "Safety All residents with orders for Measures/Restraint Evaluation and Monitoring" document, revealed on July 27, 2011, "..safety restraints will be audited and measures reviewed. Continue with pad alarm in assessments for restraints and bed &...padded side rails ...". reduction will be completed by Observation of the resident on August 1, 2011, in 8/19/2011. the resident's room, at 2:20 p.m. and 4:35 p.m., revealed the resident lying on the bed, with bilateral padded side rails in the up position and a New residents will be assessed on bed alarm in use. admission by licensed nurses and . Interview with the MDS Coordinator and Quality Assurance Coordinator, August 3, 2011, at 8:00 reported to DON or designee. a.m., in the MDS office, confirmed the facility Licensed staff will be inserviced by utilized two side rails with pads, which would be DON or designee on assessment considered a restraint for the resident, and no restraint assessment had been completed. procedure by 9/9/11. Restraint reduction assessments will be done Resident #4 was admitted to the facility on quarterly and on significant change February 20, 2007, with diagnoses including by MDS Nurse or Designee. All Dementia, Congestive Heart Fallure, and Anxiety residents with restraints will be Disorder. audited monthly for assessments Medical record review of a physicians order dated June 29, 2009, revealed "...Roll belt in bed and and compliance. w/c (wheelchair)..."

ORM CMS-2567(02-88) Provious Versions Obsolete

Observations on August 1, 2011, at 9;58 a.m.,

Event ID: SU5M11

Facility ID: YN8603

If continuation sheet Page 2 of 14

2011-08-09 14:40 DC0547PM13501 8652125642 >> DEPARTMENT OF HEALTH AND HUMAN SERVICES 4237351160 P 6/24 PKINTED: 08/08/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO, 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445424 B. WING NAME OF PROVIDER OR SUPPLIER 08/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE CENTER ON AGING AND HEALTH 880 SOUTH MOHAWK DRIVE ERWIN, TN 37650 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX COMPLETION DATE F 221 Continued From page 2 and August 2, 2011, at 8:20 a.m., in the resident F 221 Compliance will be reviewed room, revealed resident #4 sitting in bed with a monthly by the QA Nurse and soft belt (restraint) in place, Observation on reported the QA committee August 2, 2011, at 2:02 p.m., revealed resident sitting in a wheelchair with a soft belt in place. monthly consisting of 9/14/11 Administrator, Director of : Interview on August 2, 2011, at 10:01 a.m., at the Ongoing East Wing Nurse's station, with certified nursing Nursing, Safety Director, and assistant (CNA) # 1 revealed, the resident uses Department Managers, to the the call light when needs assistance and had not attempted to get out of bed unassisted for several Medical Director quarterly. , months. Interview on August 2, 2011, at 10:08 a.m., at the East Wing Nurse's station with Charge Nurse #1 revealed the resident had not attempted to get out of bed unassisted. Interview and medical record review with the Director of Nursing, on August 2, 2011, at 10:30 a.m., in the facility conference room confirmed the resident had not been accessed for a less restrictive device or restraint. F 279 463.20(d), 483.20(k)(1) DEVELOP Care Plan for resident # 9 was SS=D COMPREHENSIVE CARE PLANS F 279 immediately updated to reflect A facility must use the results of the assessment dressing changes for right lower to develop, review and revise the resident's extremities skin tear. Care plan comprehensive plan of care. updated to reflect resident #3 The facility must develop a comprehensive care nutritional needs and bi-weekly plan for each resident that includes measurable objectives and timetables to meet a resident's weights by QA Nurse. medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SUSMIT

Fecility ID: TNRRD3

No. 5885

If continuation sheet Page 3 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFINITIONS FORM APPROVE FORM APPROVE TO BE STATEMENT OF DEFINITIONS FORM APPROVE TO BE STATEMENT OF DEFINITIONS FORM APPROVE TO BE STATEMENT OF DEFINITIONS TO BE STATEMENT OF DEFINI	2011-08	-09 14:41	000	E/70MATE						
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Facility ID: TN8603 If continuation sheet Page 4 of 14	4 CM5-2567(02-99) Pravious Versions Obse	oloto	Evant in pure						
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STATEMENT OF DEFICIENC	(X1) PR	HUMAN SERVICES DICAID SERVICES DIDERISUPPLIERICLIA			FORM	08/08/201
AND PLAN OF CORRECTIO	IDE	NTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE (0938-038 SURVEY
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CENTER ON AGING			STRE	ET ADDRESS, CITY, STATE, ZIE SOUTH MOHAWK DRIVE	08/0	03/2011
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TAG REGULAT	ORY OR LOC IDENTI	OF DEFICIENCIES PRECEDED BY FULL PYING (NFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REPERENCED TO DEFICIENCE	TION SHOVED BE	COMPLETION DATE
F 279 Continued F resident war nutritional si	From page 4 s to receive wee upplements wen	kly weights and e added,	F 279	OEFICIENC	27)	
Potential for prescribed denough food needs, and weight loss plan was upochanges in denough for the plan was upochanged.	less than body let without weigh to maintain wt. weigh and mon ". Further review lated on June 2 let but no updat	requirestolerated in the loss,consume a meet nutritional interfer any significant were revealed the care	***************************************			
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Heart Fallure,	Osteoporosis,	and Glaucoma.				
observation of revealed residual a gauze wrap	n August 1, 201 ent #9 awake ar visible to the left	1. at 10:12 a.m nd alert in bed with lower leg.	İ			
Medical record dated July 25, leg 3 (three) S	review of a Phy 2011, revealed.	/sicien's order " LL (left lower) eas cleanse with n gauze and Kerlex				
, Interview with t	he Quality Assu	rance Nurse and	il			
the Minimal Da		ordinator on	ł 1		11.1	9

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	ar brosession	or arranged by the facility all standards of quality.	i	oxyger	a were change	d to 2 liters per	111	
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by:		is not met as evidenced	1	-	ons every sm	It by charge	[1]	
Besed o	n medical red	cord review, observation		nurse.	Oxygen satura	itions were	111	
. and inter	view, the faci	lity failed to follow the	}	placed	in MAR to me	Onitor every	111	- 11
hente	is order for a	nty falled to follow the the resident (#18) of		shift or	n 8/1/2011.	TARROT CVOLY	111	- 11
res citty ates	vo residents o	eviewed.		1	0/1/2011.		111	- 11
The findi	ngs included:			L				- 11
				Reside	nt's physician	orders will be	141	- 11
Resident	#18 was read	dmitted to the facility on	i	clarifie	d to include li-	ters per minute	111	-11
May 16, 2	2011, with die	gnoses including		and O2	saturations by	y QA nurse or	[]]	- 11
			i	dasia	outurations by	/ VA nurse or	111	- 11
Discase	and Sleep Ap	nea.		designe	e by 9/9/2011	3-		- [[
Medical re	ecord review	of the Minimum Data Set	1				111	11
dated May	y 23, 2011, re	or the Minimum Data Set wealed the resident scored	1	Resider	its admitted w	ith overson	111	11
12 out of	15 on the Brie	of Interview for Mental		will be	planified for 1	im oxygen	lil	11
Status (co	gnitively inte	ct), was independent with	1		clarified for li	ters per	9/9/2011	
eating and	required ext	ensive assistance with	- 11	minute	and specific D	octor's orders	9/9/2011	11
- Houvilles (of daily living.		11	for oxy	gen saturation:	s by the		11
. Medical re	Cord review	of a Physician's order	41	licensed	nurse upon a	dmission		11
dated May	16, 2011, re	vealed the resident was to	11	License	d nurses will l			11
heve Oxyg	en at 2 liters	per minute per nesal	{	DIOOHSE	d nurses will b	be in serviced	11	11
		oxygen saturations less	11	on recei	ving, transcrib	oing, and	11	
than 90%	(percent).	00400000000000000000000000000000000000	11	followir	g physician's	admission	11	
· Medical re	cord review -	if the Care Plan deted	- 11	orders fo	or oxyge and/o	or saturations	11	
		1	11	by 9/9/2	2011 by DON	on design	[]	1
M CMS-2567(02-89) Provid	oadO anelone Obse	ele Event ID: El ISAV	! !	21 31712	VII OV DON	or designee.	1	

Event ID; SUBM11

Facility 10; TN8803

If continuation sheet Page 6 of 14

DEPARTMENT OF MEALTH CENTERS FOR MEDICARE STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	DC0547PM13501 AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;		52125642 >>	7231	FOR	P 10/24 D: 08/08/201 M APPROVEI D: 0938-039
	TOWN NOMBER;	A. BUILDING	G COMSTRUCTIO	N	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER	445424	B. WING_				
CENTER ON AGING AND HEAL		STR	EET ADDRESS AIN		08/	03/2011
		1	MAHOM SILDED	, STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	i ID	RVIN, TN 97650			
· · ·	THIS INFORMATION)	PREFIX	(EADH CORE CROSS-REFER	R'S PLAN OF CORRECTIVE ACTION SHO RECTIVE ACTION SHO RENCED TO THE APPR DEFICIENCY)	TION OULD BE COPRIATE	COMPLETION CATE
administer Oxygen por facility protocol" Medical record review Administration Record August 3, 2011, revealed the extra to a sturations or the extra to a sturation of the extra to a study and 10:42 a.m., and on a.m., in the resident's	ed,"Monitor and observe hortness of breath), at MD (Physician) order or of the Medical dated May 18, 2011, thru aled no documentation of Oxygen use. To the Interdisciplinary May 29, 2011, thru August following documentation: "O2 (Oxygen) infusing to prasal cannula)O2 To the Interdisciplinary May 29, 2011, thru August following documentation: "O2 (Oxygen) infusing to prasal cannula)O2 To the Interdisciplinary May 29, 2011, thru August 2, 2011, at 2, 30 To the Interdisciplinary May 29, 2011, infusing to prasal cannula)O2 To the Interdisciplinary May 29, 2011, thru August 2, 2011, at 10;48 To the Interdisciplinary May 29, 2011, at 10;48 To the	F 281	Compliance weekly times monthly time QA Nurse or committee of Director of N Director, and	will be monitored four weeks and as three monthly designed. QA Administrator, tursing, Safety Department May with Medical	ed I by	O/14/L] & Ongoing

2011-08-09 14:43 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 4237351160 P 11/24 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (K2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING a. WING 445424 NAME OF PROVIDER OR SUPPLIER 08/03/2011 CENTER ON AGING AND HEALTH STREET ADDRESS, CITY, STATE, ZIP CODE 880 SOUTH MOHAWK DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ERWIN, TN 37650 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (X5) COMPLETION DAYE F 281 Continued From page 7 with the Director of Nursing (DON) on August 3, 2011, at 8:40 a.m., in the DON's office, confirmed F 281 the facility had not documented oxygen saturations before applying Oxygen and had not followed physician's orders for the application and use of Oxygen administration. F 325 483.25(I) MAINTAIN NUTRITION STATUS SS=D UNLESS UNAVOIDABLE F 325 Based on a resident's comprehensive Nutritional assessment was assessment, the facility must ensure that a completed by Dietary Manager resident resident # 3 and Care Plan updated (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, to reflect current malnutrition needs unless the resident's clinical condition demonstrates that this is not possible; and on 8/3/2.011 (2) Receives a therapeutic dist when there is a nutritional problem. Residents that are at risk will be identified by a dietary assessment, base line labs, and significant This REQUIREMENT is not met as evidenced weight change form then referred to Based on medical record review, observation, nutrition at risk committee facility policy review and Interview, the facility (Director of Nursing, Dietary failed to re-calculate nutritional needs and obtained weekly weights for one resident (#3) Supervisor, or their designee and with significant weight loss of twenty two Dietician) every two weeks. At risk residents reviewed. residents will be monitored as The findings included: determined by nutrition at risk committee. Nutritional assessments Resident #3 was admitted to the facility on May 20, 2010, and readmitted on July 6, 2011, with will be completed on current diagnoses of Congestive Heart Failure (CHF), resident by 8/31/2011. Pulmonary Embolism, Hypertension and Intestinal Clostridium Difficile (C. Diff). Medical DRM CMS-2587(02-89) Provious Versions Obsolete Event ID; SUSMIT Facility ID: TN8603 If continuation sheet Page 8 of 14

No. 5885 P. 9

	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	0. 0938-03
AND OF ACA	445404	A. BUILDIN	IG	COMP	LETED
AME OF PROVIDER OR SUPPLIE ENTER ON AGING AND H	EALTH	STE	REET ADDRESS, CITY, STATE, ZIF 80 SOUTH MOHAWK DRIVE RWIN, TN 37650	CODE 08/	03/2011
(X4) ID SUMMARY S PREFIX (EACH DEFICIENTAG REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE		COMPLETIO
admission on Mar 2011, related to de recurrent urinary overload. Medical record respective in the properties of each of the properties of estimated nutritic completed. Admission on Mar 2011, related to provide the properties of estimated nutritic completed.	vealed resident had been hospital for evaluation and y 31. June 27, and August 2, ecreased urinary output, tract infections (UTI) and fluid view of the Registered sciplinary Progress Note, dated ealed " reviewed for wt. 8/16/11- 124.4# (pounds). 3.6). Wt now below IBWR at Range) 118-142#, Intakes percent). Resident recently out ck 7/6/11- dx (diagnosis), CHF, t loss possibly due to fluid loss view of the Weight Report and Notes, dated July 26, 2011, and had a 12 percent significant une 6, 2011, through July 8, and review of the Dietary vealed the facility obtained July 6, July 14, July 21, 2011, i-weekly weights next due date cord review of the Dietary led July 7, 2011, revealed the elve weekly weights, nutritional added, and no re-calculation onal needs had been	F 325	Assessments will be revised as needed on a quarterly, and significant compliance will be makedly times four there times three by DON or and reported to QA con Administrator, Director Safety Director, and D Managers and quarterly Medical Director.	eviewed and dmission, ant change. onitored a monthly designee mmittee of r of Nursing, epartment	9/14/11 & Ongoing

2011-08-09 14:44 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 4237351160 P 13/24 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445424 NAME OF PROVIDER OR SUPPLIER 08/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE CENTER ON AGING AND HEALTH 880 SOUTH MOHAWK DRIVE SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEPICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ERWIN, TN 37650 PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE AOTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX COMPLETION DATE TAG F 325 Continued From page 9 ...place resident on weekly weights for one F 325 month and review these weights weekly and re-celculate estimated nutritional needs ...". Interview with the Director of Nursing and Dietary Manager, in the activities room, on August 3, 2011, at 10:10 a.m., confirmed the facility did not follow facility policy in obtaining a full month of recorded weights for the resident and did not re-calculate the residents estimated nutritional needs following a recent medical decline and significant weight loss. F 371 , 483,35(I) FOOD PROCURE SS=F STORE/PREPARE/SERVE - SANITARY No residents affected by deficiency. F 371 The facility must -(1) Procure food from sources approved or All food storage areas were considered satisfactory by Federal, State or local inspected; expired creamers and authorities; and (2) Store, prepare, distribute and serve food steak fingers were discarded. Milk under sanitary conditions expired was given back to company for credit. The standing mixer and 9/14/11 toaster were cleaned immediately. Peradm Filters were cleaned immediately. This REQUIREMENT is not met as evidenced Dietary Staff will monitor all food Based on observation and interview, the facility storage areas to include failed to store foods in a sanitary manner for one refrigerators and freezers for of two refrigerators, and falled to maintain equipment in a sanitary manner for the ice preparations dates and expirations machine, standing mixer and toaster in the dates on 8/1/2011. dletery department. The findings included: Observation and Interview on August 1, 2011, at IRM CMS-2567(02-89) Previous Versions Obsolete Evant ID: SUBM11 Facility ID: TN8603 If continuation sheet Page 10 of 14

DEPARTMENT OF USA	DC0547PM13501	86	52125642 >>	4237351160	D 14/2/
DEPARTMENT OF HEALTI CENTERS FOR MEDICARI	E & MEDICAID SERVICES			PRINTE	0: 08/08/20 MAPPROV
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE :	<u>). 0938-03</u>
	445424	A. BUILDIN	lg	- COMPL	ETED
NAME OF PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, Z	08/	03/2011
CENTER ON AGING AND HEA	ALCCC PERSON	H	80 SOUTH MOHAWK DRIVE RWIN, TN 37650	PCODE	
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR L	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCE) TO	THE APPROPRIATE	COMPLETIC DATE
on the ice machine particles and needed Observation and interest the reach in refriger confirmed a "half further serving pan, or expiration, Further confirmed a half gall with an expiration of interview confirmed had been prepared, for resident use beyone in refrigerator in the confirmed two full gallon of milk with an expiration dates of Jurgallon of milk with an expiration dates of Jurgallon of milk with an expiration dates of Jurgallon of milk with an expiration date of Jurgallon of the confirmed two full gallon of milk with an expiration date of Jurgallon of the service of the refrigerand unreadable. Interest manager confirmed the manager confirmed	Dietary Manager, in the dietary ned the outside filter and vent was visibly covered with dust of the cleaned. Serview, on August 1, 2011, at Dietary Manager, in front of ator in the dietary department. If pan of steak fingers" in a cooked, covered with no date or time of preparation or observation and interview ion of unopened whole milk ate of July 30, 2011. Further no date the "steak fingers" and the milk was available and the expiration date. Serview on August 1, 2011, at Dietary Manager, in the walk dietary department, allons of buttermilk with usy 21, 2011, and one full a expiration date of July 30, ration confirmed one box duel coffee creamers with an ine 30, 2011, and a serving ucumber with "numerous the entire surface area of a the entire surface area of a company tag hanging from rator that was black, moist view with the Dietary me milk was available for use in the entire that was black, moist view with the Dietary me milk was available for use	F 371	Daily check sheets we completed by dietary remove all expired its Appliances including cleaned after each use machine filters will be daily by dietary staff. Dietary Manager will compliance weekly times weeks then monthly. Will be reviewed by Comonthly of Administry of Nursing, Safety Dietary Department Managers quarterly with Medical	ill be staff to ems. toaster will be e. All ice e cleaned monitor for mes four Compliance A committee ator, Director rector, and s, and	
CMS-2587(02-90) Provious Versions Ob	esofolo Event ID: SUSM11	Facility	ID: YN8603	Continuation sheet Do	<u> </u>

If continuation sheet Page 11 of 14

DEPAR	3-09 14:45 RTMENT OF HEALT ERS FOR MEDICAR	DC0547PM13501 H AND HUMAN SERVICES E & MEDICAID SERVICES	865	2125642 >>	4237351160 PRINTEE): 08/08/204
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	FORM	APPROVE 0. 0938-039
010145 00		445424	B. WING		-	4.40
	PROVIDER OR SUPPLIER				08/0	03/2011
CENTE!	R ON AGING AND HE		1 ~~	ET ADDRESS, CITY, STATE, ZIP SOUTH MOHAWK DRIVE WIN, TN 37650	CODE	-72011
PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE	ON SHOULD BE	(X8) GOMPLETION DATE
SS=D	Observation and In 10:30 a.m., with the dietary department, had an "orange cold the top of the mixer and the toaster had roller bledes. Intervention of the mixer and the toaster had roller bledes. Intervention of the mixer for food preparation 483,65 INFECTION SPREAD, LINENS The facility must est infection Control Prosafe, sanitary and control program under which (a) Infection Control The facility must established the facility: (a) Infection Control The facility must established be applied to a should	terview, on August 1, 2011 at Dietary Manager, in the Dietary Manager, in the confirmed the standing mixer and the back of mixer wall, "black dried crust" on the lew with the Dietary Manager and toaster were available and needed cleaning. CONTROL, PREVENT ablish and maintain an opgram designed to provide a profortable environment and levelopment and transmission tion. Program ablish an infection Control it - cols, and prevents infections and includents and corrective cedures, such as isolation, and includents and corrective cellons. If of infection are Control Program dent needs isolation to infection, the facility must rohibit employees with a corrected skin lesions in residents or their food, if smit the disease, equire staff to wash their	F 441			
	00000 00000000 600000000 6000 6000 600	Event ID: SUSM11	Facility ID:	TN8603 If co	intinuation sheet Pag	B 72 of 14

2011-08-09 14:46 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 4237351160 P 16/24 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/08/2011 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445424 B. WING NAME OF PROVIDER OR SUPPLIER 08/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE CENTER ON AGING AND HEALTH 880 SOUTH MOHAWK DRIVE ERWIN, TN 37650 Summary Statement of Deficiencies (Each Deficiency must be preceded by full regulatory or LSC (Dentifying Information) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION DATE TAG Continued From page 12 hands after each direct resident contact for which Mentioned nebulizer for resident F 441 hand washing is indicated by accepted #13 was removed from room. professional practice. cleaned and new tubing dated and (c) Linens placed on nebulizer by CNA. Personnel must handle, store, process and Nebulizer and tubing were placed transport linens so as to prevent the spread of in plastic storage bag on 8/1/2011. O2 tubing was replaced with new tubing immediately for resident # This REQUIREMENT is not met as evidenced 18 on 8/1/2011. Based on observation, facility policy review, and interview the facility falled to follow facility policy Residents receiving nebulizer for infection control for nebulizer use for one resident (#13) and failed to follow facility policy for treatment and oxygen were checked infection control for oxygen tubing use for one resident (#18) of twenty-two residents reviewed. for proper storage and dates of tubing change by C.N.A. mentor. The findings included: C.N.A. mentor will in service other Observation on August 1, 2011, at 9:48 a.m., C.N.As on policy for tubing revealed the nebulizer and nebulizer tubing for changing and storage of nebulizer resident #13 was uncovered and the nebulizer tubing was undated. and O2. Charge nurses will check all oxygen tubing and nebulizers Observation and interview with Charge Nurse #2 on August 1, 2011, at 1;59 p.m., in the resident's during A.M. med pass for room, confirmed the nebulizer for resident #13

RM CMS-2567(02-99) Provious Versions Obsolete

was uncovered and should have been placed in a

Review of the facility policy for Nebulizer Treatment revealed, "...dismentle the nebulizer

and rinse it under a stream of water. Allow the

nebulizer to air dry, then reassemble it and place It and tubing in a plastic bag. Change tubing and

plastic storage bag when not in use.

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Facility ID: TNggna

every week.

compliance daily to assure

nebulizer tubing and equipment are

in plastic bag. Nebulizer and O2

tubing will be replaced and dated

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2011-08-09 14:46 DEPARTMENT OF HEALTH CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES	E MEDICAID SERVICES	86	52125642 >>	FOR	D: 08/08/2011 MAPPROVED
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	<u>0. 0938-0391</u> SURVEY
NAME OF PROVIDER OR SUPPLIER	445424	B. WING			
CENTER ON AGING AND HE		, ,	EET ADDRESS, CITY, STA 80 SOUTH MOHAWK DR RWIN, TN 37650	TO SID COMO	03/2011
TAG REGULATORY OR L	SO IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PL (EACH CORRECT!) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X8) GOMPLETION DATE
Resident #16 was re May 16, 2011, with a Pheumonia, Chronic Disease, and Sleep Medical record revie dated May 16, 2011, per minute per nasa oxygen saturations in the date of the setting at 1.5 liters per tubing was lying in the not available for residence of the residence of the setting that continued to the setting that continued the setting	irector of Nursing (DON) on 2:09 a.m., at the east hall firmed the facility policy for followed. Beadmitted to the facility on diagnoses including constructive Pulmonary Apnea. W of a Physician's order revealed Oxygen at 2 liters cannula as needed for east than 90% (percent), ast 2, 2011, at 10:20 a.m. relied the resident was lying to oxygen concentrator minute, and the oxygen a floor, behind the bed, and lent use. Observation as floor, behind the bed, and lent use. Observation as floor, behind the bed, and lent use. Observation at floor without to remove the dirty oxygen to lie on the floor. Wiew on August 2, 2011, at dent's room, with Licensed infirmed the oxygen tubing and tubin	F 441	Compliance will It C.N.A. mentor we reviewed by QA of Administrator, Di Safety Director, at Managers monthly with Medical Director of the Medical Dire	cekly and committee of rector of Nursing, and Department y and quarterly	9/14/11 & Ongoing
CMS-2587(02-99) Providud Varcions Oba	olate Svent ID: SU5M11	Pacifity to	D: TN6603	If continuation sheet Pag	10 14 of 14